STATEMENT BY
LIEUTENANT GENERAL THOMAS P. BOSTICK
DEPUTY CHIEF OF STAFF G-1
UNITED STATES ARMY

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL

FIRST SESSION, 112TH CONGRESS

ON SUICIDES AND SUICIDE PREVENTION IN THE ARMY

SEPTEMBER 9, 2011

NOT FOR PUBLICATION
UNTIL RELEASED BY
THE COMMITTEE ON ARMED SERVICES

STATEMENT BY
LIEUTENANT GENERAL THOMAS P. BOSTICK
DEPUTY CHIEF OF STAFF G-1
UNITED STATES ARMY

Chairman Wilson, Ranking Member Davis, distinguished Members of the Subcommittee; I thank you for the opportunity to appear here today to provide a status on the United States Army's ongoing efforts to reduce the number of suicides across our Force; and, also detect and care for Soldiers suffering from post-traumatic stress, traumatic brain injury and other behavioral health issues.

On behalf of our Secretary, the Honorable John McHugh and our Chief of Staff, General Martin E. Dempsey, I would also like to take this opportunity to thank you for your continued, strong support and demonstrated commitment to our Soldiers, their Families, and Army Civilians.

It has been a busy time for our Nation's military. We are at war; we have been at war for nearly ten years. That has undeniably put a strain on the men and women serving in the Army today – and their Families. Many individuals have deployed multiple times. A significant number of them suffer physical injuries, such as musculo-skeletal damage, amputations, bullet or shrapnel wounds, traumatic brain injury, or burns. These wounds are easy to see. However, there are also those who suffer from the "invisible wounds of war;" behavioral health issues, such as depression, anxiety and post-traumatic stress. The resiliency of these men and women is astounding exactly because of the challenges they face, not in spite of them. These are well-trained, highly-motivated, and deeply patriotic individuals; and they are doing an outstanding job on behalf of the Nation.

As leaders, we are responsible for both the physical and psychological well-being of these individuals. The Army continues to work diligently to address these invisible wounds of war by identifying ways to alleviate some of the stress on our Force while also improving our ability to detect, prevent, and treat these injuries. We are dedicated to improving resiliency; eliminating the long-standing, negative stigma associated with seeking and receiving help; and, ensuring that Soldiers, Army Civilians and Family Members who may be struggling get the help that they need.

Calendar Year (CY) 2010 and CY 2011 Army Suicide Reports

Between 2004 and 2010, suicides in the United States Army were on the rise. In CY 2009, we had 162 active duty suicide deaths (including activated members of the

National Guard and Army Reserve), with 244 across the total Army. During this same period, we had 1,679 known attempted suicides.

In CY 2010, we continued to see an increase in suicide numbers. The Army had 155 active duty suicide deaths (including activated members of the National Guard and Army Reserve), with 300 across the total Army. During this time we also had 1079 known attempted suicides.

To date in 2011, we are seeing what appears to be a leveling off of suicide numbers, rather than an increase.

As of 30 Jun 2011, there were 76 active duty suicide deaths (includes 2 activated USAR Soldiers and 4 activated ARNG Soldiers); for the same time period last year there were 79.

Among the Reserve Component Soldiers not on active duty we have seen 49 suicides as compared to 68 for the same time period last year. For Army National Guard, we have seen 33 suicides as compared to 53 for the same time period last year. For Army Reserve, we have seen 16 suicides as compared to 15 for the same time period last year.

We also track suicides among Department of the Army Civilians [total as of 30 Jun 11 for DA Civilians is 17 as compared to 19 for the same time period last year] and Family Members [total as of 30 Jun 11 for Family Members is 3 as compared to 5 for the same time period last year].

The loss of any Soldier or Army Civilian to suicide is tragic, incomprehensible, and unacceptable. Each of these suicides represents an individual and a Family that has suffered an irreparable loss. Army leadership is working to better understand the causes of the current trend in Soldier suicides and we've instituted prevention measures that recognize everyone in the Army must be part of the solution.

Stress, High Risk Behavior, and Leadership Awareness

The act of committing suicide is generally preceded by not one, but a combination of events that together triggers a feeling of helplessness. Examination of suicide events has shown that common risk indicators include substance abuse, encounters with law enforcement, relationship issues, and financial concerns. The Army has dedicated a number of resources to training our Soldiers and Leaders to identify these factors and intercede on the Soldier's behalf to get them the assistance that they need to address these concerns. We are training both Leaders and Soldiers to becoming more aware of

the challenges individuals in the Army face, and the programs and services available to help support them.

Army Suicide Prevention Task Force –A Team Approach

Since the inception of the Army Suicide Prevention Task Force (ASPTF) – a group of multi-disciplinary representatives from across the Army staff – in March 2009, the Army has completed a number of actions to combat high risk and suicide behavior.

Over the past two years, the task force identified risk factors and indicators that help potentially illuminate correlations to high-risk and suicidal behavior in the Army. Their effort resulted in the publication of the Army Health Promotion, Risk Reduction and Suicide Prevention Report in July 2010. This report provides a comprehensive review of Army policy, process, structure, and programs, and identifies gaps in how we see, identify, engage, and mitigate high-risk Soldiers.

The task force, together with the Army Suicide Prevention Council (an interim HQDA-level organization chartered under the authority of the VCSA and mandated to expedite solutions from HQDA through appropriate commands), is charged with facilitating the implementation of these recommendations. Its unique governance, policy, structure and process have greatly expedited implementation of many strategic changes, including:

- Produced two interactive training videos that included scenarios for Active, National Guard and Reserve Soldiers; Army Civilians; and Family Members: “The Home Front” and “Beyond the Front.”
- Produced the “Shoulder to Shoulder” training video series, which includes “Soldier to Soldier: No Soldier Stands Alone” and “Soldier to Soldier: I Will Never Quit on Life” training video. A third video is scheduled to be released in the Fall.
- Initiated “face-to-face” post-deployment behavioral health screening (in person or virtual) for all Brigade Combat Teams.
- Increased the number of Military Family Life Consultants (MFLCs) that work with children and families to provide them support during transitions and separations. Increased from 23 in FY07 to over 270 in FY10. These MFLCs are embedded in youth service facilities and in on- and off-post schools.
- Implemented “Pain Management Task Force” in August 2009 to make recommendations to appropriately manage the use of pain medications and adopt best practices Army-wide. The Pain Management Task Force Final Report was published in May 2010 and current efforts are underway to implement the recommendations.

- Implemented a “Comprehensive Behavioral Health System of Care Campaign Plan” to improve the coordination of behavioral health care across all medical disciplines.
- Implementation of the Army Confidential Alcohol Treatment and Education Pilot at six installations (Schofield Barracks, JB Elmendorf-Richardson, JB Lewis-McCord, Ft. Carson, Ft. Riley, and Ft. Leonard Wood).

VCSA Suicide Senior Review Group

In an effort to learn as much as possible from every suicide, in March 2009 the Vice Chief of Staff of the Army established the monthly VCSA Suicide Senior Review Group (SRG). The SRG involves senior commanders from affected commands across the Army. The SRG reviews approximately 15 to 20 suicide cases each month. The cases are discussed to glean lessons learned and identify trends and themes in an effort to help prevent future suicides. In addition to lessons learned, this is a chance to share success stories and learn best practices from the various Army commands.

Also, to aid in gaining as much information as possible from every suicide, the task force developed a suicide event collection report, comprised of data fields to be filled in by the Field Army. The report provides Army leadership with instant, actionable information on each individual Army suicide within approximately 72 hours of the Criminal Investigation Command’s initial response.

Learning More Through Research

The Army recognizes that effectively addressing the challenge of Soldier suicides will require a team effort across all Army components, jurisdictions, and commands, as well as continued cooperation with partners outside of our organization.

U.S. Army Medical Research and Materiel Command (MMRC) is currently managing thirteen medical suicide prevention research projects; a total investment of $79 million. These projects include Walter Reed Army Institute of Research project on suicide ideation in a combat environment.

In addition, the Army has entered into a Memorandum of Agreement with the National Institute of Mental Health (NIMH) in connection with the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). The Army STARRS effort represents the largest DoD longitudinal epidemiologic study of mental health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths in the Army, and is the largest single study on the subject of suicide that NIMH has ever undertaken. Army

STARRS aims to guide the development of data-driven methods to reduce or prevent suicide behaviors and improve Soldiers' overall mental health and functioning by identifying the most important risk and protective factors. . The Study includes Soldiers from every component of the Force – Active Army, Army National Guard, and Army Reserve. The Study consists of four components:

- The Historical Data Study involves the examination of more than 1.1 billion redacted historical health and administrative records to detect risk and protective factors related to psychological resilience, mental health, risky behaviors, and suicide. To date, NIMH has conducted preliminary data analysis and is currently in-process of beginning analysis of the full data set.
- The All Army Study will assess Soldiers' psychological and physical health; events encountered during training, combat, and non-combat operations; and life and work experiences across all phases of the Army service. Researchers will use this information to determine how these factors affect Soldiers' psychological resilience, behavioral health, and risk for self-harm. Data collection began in January 2011.
- The New Soldier Study will assess the health, personal characteristics, and prior experiences of volunteers from the pool of newly inducted Soldiers as they begin their Army career. Data collection began in January 2011.
- The Soldier Health Outcomes Study is comprised of two comparison studies in which investigators will identify characteristics, events, experiences, and exposures that predict negative or positive health and behavior outcomes using study participants from across all phases of the Army service. NIMH has been working on study plan development and obtaining approval of research protocols; they anticipate beginning data collection in the 3rd quarter of 2011.

The Military Suicide Research Consortium is a long-term, multidisciplinary suicide research collaboration between the University of Colorado Denver/Denver Veterans Administration Medical Center and Florida State University. This consortium supports the development and evaluation of evidence-based interventions, including screening, treatment, prevention and postvention. Among the research projects supported within this forum, there is a current effort to develop an integrated digital library of suicide research that will serve as a resource for researchers, policymakers, and others to inform current screening, treatment, prevention, and postvention methods, as well as future research efforts.

Other MRMC supported research initiatives include a study into the association between antidepressant use and suicidal behavior among younger veterans (Harvard University); an evaluation of the efficacy of brief safety planning interventions on hospitalized active duty military patients and outpatients though the Uniformed Services

University of Health Sciences; and a retrospective study of theater evacuations for suicidal behavior to examine suicidal ideation in combat zones.

Through these partnerships, we are confident that we can develop a better comprehensive understanding of the manifestation of suicidal behaviors, as well as effective screening, treatment, prevention, and postvention strategies within the military population. We hope that collectively these studies will lead to a more thorough understanding of the cumulative effect of transitions of all types (accession, permanent change of station, death of family member, temporary change of station, retirement, etc.) and stressors across a Soldier's entire career to develop tailored interventions based on known or predictive levels of stress. The results will benefit the Army, the other military Services, as well as the U.S. population overall, and may lead to more effective interventions for both Soldiers and civilians.

Behavioral Health Care

As mentioned previously, our Soldiers are under a great deal of strain. It is our responsibility to ensure that they are not only taking care of themselves physically, but psychologically as well. The Army continues to emphasize the importance of seeking behavioral health care and to dispel the myth that seeking care might jeopardize a Soldier's career prospects or reputation among his/her peers.

Soldiers are recognizing the importance of individual help-seeking behavior and commanders are realizing the importance of intervention at the leadership level. In FY 2010, 257,537 Soldiers accessed outpatient behavioral health care (ranging from screening to therapy) and 9,392 Soldiers received inpatient behavioral health care. This is an increase from 216,222 and 9,201 in FY 2009. Within behavioral health clinics, the Army increased the number of monthly clinic encounters from 94,784 to 105,898 during FY10, a 12% increase. These numbers indicate that our efforts to emphasize the importance of behavioral health are working.

The Army also continues its efforts to provide a sufficient number of behavioral health providers. The nationwide shortage of behavioral health care providers continues to present a significant challenge, but we have made great strides in meeting the Army's needs. The Army has approximately 4,600 behavioral health providers on-hand, an increase of 1,745 since 2007. This represents 92.7% of the total number of behavioral health providers needed. Psychiatrists, Marriage Family Therapists, and Social Workers are the greatest shortages; the Army continues efforts to recruit these professionals.

Our continued focus on access to behavioral health care led to the funding of 40 unique psychological health programs in FY 2010. These programs provide a range of

expanded healthcare services to our beneficiaries and obligated over $168 million additional dollars to behavioral health services. This includes the implementation of programs such as RESPECT-MIL and the medical home model, to increase opportunities for behavioral health monitoring in the primary care setting.

Web-based Behavioral Health Care Services

For Army men and women who are geographically isolated or otherwise may not have easy access to in-person behavioral health care, TRICARE has implemented the TRICARE Assistance Program (TRIAP) for Soldiers and Family Members. The program is open to:

- Active duty Servicemembers
- Members eligible for the Transition Assistance Management Program (TAMP) for 6 months after demobilization
- Members enrolled in TRICARE Reserve Select, as well as Spouses and Family Members 18+ years

Soldiers and Family Members can access unlimited short-term, problem-solving counseling 24/7 with a licensed counselor from home, or any other location, with a computer, Internet, required software download, and webcam. If more specialized medical care is deemed necessary, an immediate warm handoff can/will be made to a medical provider.

From August 2009 to May 2011, 4283 calls were recorded. The Army was the primary branch of Service represented in this population (40% of callers were Army). Among the calling population, the six most common concerns of the callers were: partner relational problems, stress management, next of kin relational problems, stress related to deployment, phase of life problem, and self esteem. We are pleased to see that this program is being used across the components. This provides yet another avenue for Soldiers to seek support when they need it.

In conjunction with TRIAP, the Army continues to work to build a network of locations and on-line providers for telebehavioral health services, using medically-supervised, secure audio-visual conferencing to link beneficiaries with offsite providers. This network will be able to provide the full range of behavioral healthcare services, including psychotherapy and medication management. Our long-term goal is to create a network of counselors and certified behavioral healthcare providers that encompass the entire U.S. to ensure that all Soldiers have access to care no matter where their location.

Support for Geographically Isolated Populations

The Army is continuing to bridge programs and services to RC Soldiers and Families when not on AD.

- Telehealth services are just one means by which the Army is addressing the needs of geographically isolated populations, and specifically our Reserve Component Soldiers and Families.
- The Army is improving awareness of and access to training and resources; working with employers and private sector to mitigate economic stress; and improving the quality and access to health care for all RC Soldiers.
- We have implemented a number of programs, including:
    - The Yellow Ribbon Reintegration Program pro-actively reaches out with information, education, services, and referrals through all phases of the deployment cycle.
    - The Strong Bonds program's mission is to increase Soldier and Family readiness through relationship education and skills training. Strong Bonds helps single Soldiers, couples and Families thrive in the turbulence of the military environment.
    - The Army Strong Community Center program was established by the Army Reserve to support Military Members and their Families who live away from the larger military installations where support is readily available. There are currently 3 Army Strong Community Center locations in Rochester, NY; Brevard, NC; and Coraopolis, PA.
    - The Employer Partnership (EP) is a key program to help mitigate economic stress on Reserve Component Soldiers. EP was created as a way to provide America's employers with a direct link to some of America's finest employees – Service members and their families. EP's partnering with over 1,000 employers who include 96 of the 2010 Forbes Fortune 500 Companies, and the list is growing.
    - The Transitional Assistance Management Program (TAMP) provides 180 days of transitional health care benefits, including psychological health care, to demobilized Reserve Soldiers and their families.
    - Military OneSource. Military OneSource is an information and referral clearinghouse that can guide AR members to the right resources. Through Military OneSource, the Soldier and each family member has access to up to 12 in-person counseling sessions with a licensed counselor at no cost.

Changing Culture

In the past, there has been a stigma associated with seeking help from any kind of behavioral health professional. Soldiers avoided seeking this type of assistance for fear that it might adversely affect their careers. However, that is not the case; and, we are taking the necessary steps to change this misperception across the Army.

We have implemented novel, broad-based approaches to raising awareness about behavioral health and suicide prevention. These include public service announcements using celebrities, Army leaders, and Medal of Honor Recipients; advocacy and outreach messages and programs through organizations like Blue Star Moms; focused efforts in publications such as PS Magazine; and educational videos such as Shoulder to Shoulder. Through these and other programs, we are slowly changing the Army culture concerning the perceived stigma of behavioral health.

The Army has implemented confidential support programs such as Military OneSource to act as a bridge while we move forward in removing the stigma from behavioral health concerns. In the future, we hope that we do not need confidential support programs; that a Soldier can recognize he or she needs help and can seek it out without fear of professional fallout.

The Hidden Challenges: Traumatic Brain Injury and Post-traumatic Stress

One of the challenges in preventing suicide is recognizing that an individual – even a close family member or good friend – is considering taking his or her own life and may need help. Too often individuals will suffer in silence. They may be dealing with severe depression or anxiety and choose to hide their concerns from family and friends.

Traumatic brain injury (TBI), post-traumatic stress (PTS), and behavioral health issues can present similar significant challenges. These injuries pose unique challenges, especially as compared to easily-detectable wounds such as amputations and burns. PTS and TBI are among the most difficult to correctly diagnose and treat, while their debilitating effects are constant hurdles to effective treatment, and recovery. The study of the human brain is an emerging science; there is still much to be learned about these and other highly-complex injuries involving the brain. This pertains not just within the military community, but throughout the global medical community.

In a concerted effort to minimize the number and severity of injuries, the Army implemented a new TBI management strategy across the force aimed at prevention, early detection and effective treatment of injuries. Additionally, the Army is instituting a revised program of instruction for medics and other behavioral health providers that includes training specific to TBI and PTS injuries. We're also incorporating instruction

on this important issue into training programs at the National Training Center, Joint Readiness Training Center and other locations.

The new TBI management strategy, *"Educate, Train, Treat & Track,"* is also being successfully implemented downrange. Deploying Soldiers receive training prior to their arrival in theater. The new TBI management strategy also includes strict "event-based" protocols that govern exactly what Leaders and Soldiers must do if involved in a concussive event. This strategy specifies criteria to determine an event and specifies the protocol that every exposed Soldier must undergo, to include a medical evaluation and, pending the findings of the exam, a mandatory 24-hour downtime period and a second exam before returning to duty. We cannot permit the proud "Warrior Spirit" of our Soldiers, which leads many of them to ignore their concussions and remain in the fight, to needlessly expose them to another brain injury during the vulnerable period of healing.

Since 2002, the Department of Defense has opened over 50 TBI treatment centers across the country. These centers are staffed with multidisciplinary teams of medical providers capable of treating the full range of TBI, from mild to severe. The National Intrepid Center of Excellence, in Betheseda, MD, a state of the art research, diagnosis, and treatment facility for Servicemembers and Veterans with diagnosed traumatic Brain Injury and psychological health conditions, was officially opened in June 2010. It is the DoD's largest and most advanced medical complex and is across from the National Institute of Health—a key partner in advancing the science and treatment of these injuries and illnesses.

We are making progress, but it remains an incredibly challenging endeavor and the Army remains committed to advancing research to inform screening and treatment of these conditions. We are continually making improvements to the care and services provided to our Soldiers through sharing best practices and lessons learned.

Prescription Drug Use

Given the nature of the injuries sustained by the men and women serving in the Army, prescription drugs, including pain, depression, and anxiety medications may be prescribed as part of a comprehensive treatment plan. While we recognize the utility of these medications to treat the injuries, the Army is also aware of the potential for prescription drug abuse. Army Health Promotion, Risk Reduction and Suicide Prevention Report in July 2010 found that prescription drug abuse is on the rise in the Army. The Army is pursuing a number of avenues to address this issue.

We are working with the legal and medical communities to improve transfer of information between commanders, medical professionals, and program and service providers, while ensuring we protect the privacy rights of patients.

We have recently implemented a program that limits the prescribing of most Schedule II controlled substances (including opiates and narcotics for pain relief, and amphetamines such as those used to treat attention deficit disorder or depression) to a 30-day prescription rather than the previously accepted 90-day prescription. Additionally, we have implemented a policy whereby Soldiers found using Schedule II controlled substances six months from the date the final refill was obtained can face disciplinary action. These measures are meant to decrease the prolonged access of Soldiers to Schedule II controlled substances without medical supervision.

To complement this effort, the Army is also pursuing permission from the DEA to implement a drug take-back program at all Military Medical Treatment Facilities. Beginning in 2010, the DEA implemented a National Drug Take-back Day where citizens were allowed to relinquish their Schedule II controlled substance prescriptions to authorized facilities. On April 30, 2011, the Army participated, giving Army Soldiers and Families the opportunity to dispose of unused or expired prescriptions. Thirty-eight collections sites at twenty-seven installations reported collecting over 1150 pounds of unused or expired medications. The program was a resounding success, and demonstrates the need for regular access to this type of service.

We are addressing the need for more comprehensive management of prescription medication. In doing so, we are decreasing the likelihood that illicit use of prescription drugs might influence a suicide attempt or event.

Closing Remarks

Any time a Soldier, Army Civilian, or Family member chooses to end his or her life, the loss is devastating to Family and friends, fellow Soldiers, and the Army. Throughout my career in the Army, I have never dealt with a more difficult or critical mission than the current charge to reduce the number of Soldier suicides and properly diagnose and treat individuals suffering from TBI, PTS and behavioral health issues.

Over the past year, our commitment to health promotion, risk reduction and suicide prevention has changed Army policy, structure and processes. We have implemented a multi-disciplinary approach and a team effort by Leaders and Soldiers at all levels of command and across our Active and Reserve components – together with DoD, Congress, and willing civilian health care providers, research institutes, and care facilities – to ensure that we are providing our Soldiers with the most effective programs,

treatments, and support. We have seen success in our efforts, including more Soldiers seeking behavioral health care, more programs to support our Reserve Component, and a greater awareness among Soldiers and Leaders about suicide and high-risk indicators.

Our success notwithstanding, we still have much more to do. We face an Army-wide problem that can only be solved by the coordinated efforts of our commanders, leaders, program managers and service providers. The Army remains committed to this effort and to supporting all of the men and women who serve in the Army.

I assure the esteemed Members of this committee that there is no greater priority for me and the other senior leaders of the United States Army than the safety and well-being of our Soldiers. The men and women who wear the uniform of our Nation are the best in the world, and we owe them and their Families a tremendous debt of gratitude for their service and for their many sacrifices.